Pertussis Contact Investigation Worksheet

Case Name:____

Contact Information	Demographics	Relationship to Case	Symptoms	Treatment/Prophy Recommendations	Immunization History* *Document only medically verified pertussis vaccine, (i.e., school records, immunization card, health care provider records. Parent/guardian verbal report is not a medically verified report).
Name: Phone: Address City: State:	DOB: ___/___/______ Male☐ Female☐ Race: ______________ Ethnicity: _______	Household ☐ Other ☐ _______________ (Specify) Infants <1 yr. in home Y☐N☐ PG female in home Y☐N☐	Cold symptoms Y☐ N☐ Cough. Onset date ___/___/___ Y☐ N☐ Cough for 2 wks or more Y☐ N☐ Paroxysm Y☐ N☐ Whoop Y☐ N☐ Vomiting Y☐ N☐	Azithromycin Other:_____________ Start Date: ___/___/_____ N/A ☐	DTaP/ Tdap Immunization and Date Dose 1 Dose 2 Dose 3 Dose 4 Dose 5 Dose 6
Name: Phone: Address City: State:	DOB: ___/___/______ Male☐ Female☐ Race: ______________ Ethnicity: _______	Household ☐ Other ☐ _______________ (Specify) Infants <1 yr. in home Y☐N☐ PG female in home Y☐N☐	Cold symptoms Y☐ N☐ Cough. Onset date ___/___/___ Y☐ N☐ Cough for 2 wks or more Y☐ N☐ Paroxysm Y☐ N☐ Whoop Y☐ N☐ Vomiting Y☐ N☐	Azithromycin Other:_____________ Start Date: ___/___/_____ N/A ☐	DTaP/ Tdap Immunization and Date Dose 1 Dose 2 Dose 3 Dose 4 Dose 5 Dose 6
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Comments:

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